PRINTED: 08/18/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII	TIDI E CON	NSTRUCTION	(X3) DATE	SUDVEV
l l			(AZ) MUL	TIPLE CO			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPI	
			B. WING			08/01/2	ררטי
NAME OF E	PROVIDER OR SUPPLIER	?		STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	NO VIDER OR SUFFLIER			2075 RII	PLEY STREET		
LAKE PARK RESIDENTIAL CARE INC					TATION, IN46405		_
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	IATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
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	This visit was fo	or the Post Survey Revisit	R00	00			
	to the State Lice	nsure Survey completed					
	on May 11, 2011						
	, ,						
	Survey Date: A	uguet 1 2011					
	Survey Date. A	ugust 1, 2011					
	Facility Number	·· 001136					
	Provider Number						
	AIM Number: 1	N/A					
	C						
	Surveyor						
	Heather Tuttle, I	R.N. T.C.					
	Canana Dad Tan						
	Census Bed Typ	e.					
	128 Residential						
	128 Total						
	Census Payor Ty	/pe:					
	128 Other						
	128 Total						
	Sample: 11						
	•						
	These State Resi	idential Findings are cited					
		ith 410 IAC 16.2.					
	in accordance w	iui 710 IAC 10.2.					
	i		1				i

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
	B. WING				08/01/2011			
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET LAKE STATION, IN46405					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE	
R0050	personal affairs an manages these se written request, all or part of their fina does not include the items. If the facility resident 's funds, (1) provide the resuccounting of all fithe facility; (2) provide the resuccounting of all fithe facility; (2) provide the resuccounting of all fithe facility; (2) provide the resuccounting business hof all financial transindividual resident (3) provide for a sefacility funds; (4) return to the reand within no later days, all or any pagiven the facility for (5) deposit, unless federal law, any reexcess of one hun interest-bearing accounts and that on the resident 's (in pooled accounting for eaccounting for eaccounting for eaccounting for eaccounting, accordaccounting, accordaccounting, accordaccounting princip personal funds entresident 's behalf;	ident with a quarterly nancial affairs handled by ident, upon the resident 's pnable access, during ours, to the written records sactions involving the 's funds; eparation of resident and sident, upon written request than fifteen (15) calendar it of the resident 's funds or safekeeping; to therwise required by sident 's personal funds in dred dollars (\$100) in an account (or accounts) that is of the facility 's operating credits all interest earned funds to his or her account is, there must be a separate the resident 's share); ent 's personal funds that the hundred dollars (\$100) in a graccount, interestbearing that it is plete, and separate ding to generally accepted les, of each resident 's trusted to the facility on the						

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NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET LAKE STATION, IN46405					
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	during normal bus the resident 's ac (9) provide the resident reasonable access hours to the writte transactions involves funds; (10) provide to the representative a condition individual financial resident or his or statement of the inupon the request resident 's legal resident who has with the facility, the final accounting or individual or probathe resident 's es Based on record the facility failed received interest greater than 100 residents review of 11. (Resident #11) Findings include Review of the Resident #7 had	sident or the resident's we upon request with so during normal business in records of all financial wing the individual resident'. The resident or his or her legal quarterly statement of the larged representative and individual financial record of the resident or the resident or the representative; and (11) the supersonal funds deposited the resident's funds and a fact those funds to the rete jurisdiction administering tate. The review and interviews, and to ensure every resident on their money for funds to the resident for 5 of 5 and for funds in the sample as #7, #8, #9, #10, and	R0050	1. What corrective actic accomplished for those found to have been affer the deficient practice? F #7 no longer resides in facility. Resident#8 has allocated. Resident#9 resides in the facility. Resident#10 has intere allocated. Resident#11 interest allocated. Interest allocated for January 20 2011 for residents who balances greater than chundred (100.00) dollar Resident #7 and 11 has discharged from the community and the interest allocated for the tithey resided in the facility.	residents coted by Resident the sinterest no longer st has est was 009 to July had one s. re been rest has	09/15/2011		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2075 RIPLEY STREET LAKE PARK RESIDENTIAL CARE INC LAKE STATION, IN46405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Resident #9 had \$286.00 in the account. balances greater than one hundred (100.00) dollars. 2.How Resident #10 had \$355.74 in the account. will the facility identify other Resident #11 had \$357.21 in the account. residents having the potential to be affected by the same deficient practice and what corrective Review of the 2009 and 2010 bank actions will be taken? All statements for each of the above residents of Lake Park mentioned residents indicated no interest Residential who have balances had been credited to their accounts. greater than one hundred Earned interest was credited to the above (100.00) dollars in in resident fund accounts have the potential residents' accounts on 12/9/08. No to be affected by this alleged interest had been credited to any of the deficient practice. All residents residents' accounts for 2011. with co-op accounts or who have Lake Park manage their funds will be given the Authorization for Review of the Admission Packet provided Resident Funds Handling that will by the Administrative Assistant on 8/1/11 require their signature of at 3:00 p.m., indicated a "Consent authorization. The Authorization for Resident Fund Handling has Treatment" form which indicated the been updated and will remain a Authorization for Resident Fund form in the Admission Packet for Handling. This form indicated, "The Lake Park Residential. 3. What undersigned does hereby grant to the measures will be put into place or facility permission to execute the financial what systemic changes the facility will make to ensure that the affairs of the above designated resident. deficient practice does not The authorization may apply to all recur?The resident funds will financial affairs except as is herein remain in an interest bearing designated (limitations). It has been account. The Corporate account who prepares the bank explained to me that with the granting of reconciliation will run a Summary this of this authorization, the facility shall Report as of the end of the provide a quarterly accounting of affairs month. The interest earned from handled according to the written records the interest bearing account will be allocated, one cent each, to of these transactions and return of the residents with the balances of remaining funds within fifteen (15) days one hundred dollars or more until subsequent to receipt of written request the interest has been exhausted. for same. The authorization shall be valid Should interest rate increase so that the earnings exceed more for the period of time in which I am in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2075 RIPLEY STREET LAKE PARK RESIDENTIAL CARE INC LAKE STATION, IN46405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE residence at this facility unless a specified than one cent with balances more than one hundred, the account expiration date is herein requested will allocate the earnings on a (expiration date, if any)" ratio of each's balance to the total of all residents balance greater than one hundred (100.00) Review of the Admission Business files dollars. Any service charges for the above mentioned residents made by the bank will be paid by indicated none of them had signed this Lake Park Residential. 4.How document regarding resident funds. the corrective actions will be monitored to ensure the deficient practice will not recur? The Review of the Plan of Correction accountant preparing the bank indicated "The Corporate office that is reconciliation will be in-serviced handling the interest to be credited will be on how to allocate the interest to inserviced on the regulations regarding resident accounts. The controller will review the allocation entry and personal fund accounts. The Business will send the report to the Office Manager that handles the resident Administrator with notification of personal fund accounts in the facility will the allocation and the residents' balances. The Business Office be inserviced on the regulation. The Manager and the Administrator Business office manager will ensure the will monitor the resident fund interest has been credited to resident accounts monthly to ensure that person fund accounts in excess of one the interest has been added to hundred (\$100) dollars on a quarterly resident balances greater than one hundred (100.00) dollars. basis." The Business Office Manager in conjunction with the Corporate Interview with the Corporate Manager on Account and Controllers Office 8/1/11 at 1:00 p.m., indicated the will ensure that residents receive quarterly statements and the corporation was instructed in 2007 to Administrator will monitor for place the resident funds into an interest compliance. The Corporate bearing account. At that time, all of the accountant and Controller willbe funds were transferred to an interest inserviced on maintaining resident funds in an interest bearing account. She further indicated the bearing account. Monitoring will bank started charging the corporation be ongoing. 5.By what date the monthly service fees and these fees were systemic changes will be greater than the interest being earned completed? Systemic changes will be completed by September monthly. She also indicated the

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	residents any interest earned from 2011. She in interest earned from 2010, and 2011. Monthly service charging was gree being earned. Interview with the Manager on 8/1/2 none of the reside greater than 1000 any interest from 7/31/11. She also that she did not be received quarter. Interview with the 8/1/11 at 1:00 p. 1 unaware the corporate resident accorporate accorporate indicated she was using the interpretation. This State Reside 5/11/11. The face	not credit any of the crest in 2009 or 2010 and dicated they used the com the resident accounts ly service fee in 2009, She indicated the fees the bank was eater than the interest on the Business Office 11 at 1:00 p.m., indicated ents with bank accounts 00 dollars had received at the two years past as of the indicated at the time, know if the residents y statements. The Administrator on m., indicated she was coration was not crediting unts with their interest or money. She also is unaware the corporation erest earned to pay the fee being charged by the cential Rule was cited on the correction to prevent in the correc			15, 2011.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2075 RIPLEY STREET LAKE PARK RESIDENTIAL CARE INC LAKE STATION, IN46405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE R0241 (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident 's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. 1. What corrective actions will be 09/15/2011 R0241 accomplished for those residents Based on record review and interview, the facility affected by the deficient failed to ensure a licensed nurse was monitoring practice?Resident#2 is not in and supervising the administration of medications facility at this time.Resident#3's and residential nursing care as ordered by the blood glucose monitoring has physician related to insulin administration and been performed and blood glucose testing for 3 of 11 sampled residents documented.Resident#4 no reviewed for following physician orders. longer resides in the facility.2. (Residents #2, #3, & #4) How will the facility identify other residents having the potential to be affected by the same deficient Findings include: practice? All residents with orders for blood glucose monitoring have 1. The record for Resident #2 was reviewed on the potential for being affected by 8/1/11 at 2:15 p.m. The resident's diagnoses this deficient practice. Residents included but were not limited to non-insulin with blood glucose monitoring diabetes. records are being audited by the Director of Nursing and or Review of Physician orders, dated 7/2/11, designee.3. What measures are indicated blood glucose monitoring on Mondays, being put into place or what Wednesdays, and Fridays at 4:00 p.m. systemic changes the facility will make to ensure that the deficient Review of the Finger Stick Blood Glucose praactice does not recur?A directed in-service has been Monitoring/Sliding Scale Insulin coverage Administration Record for the month of July 2011 conducted with all the nurses including the Director of Nursing, indicated a blood glucose was obtained only one responsible for nursing care in the time on July 18, 2011 at 5:00 p.m. There were facility. Competency testing has two readings recorded that day. There was no been conducted with all the other blood glucose readings for the rest of the nurses including the Director of month. Nursing, responsible for the nursing care in the facility and the Interview with LPN #1 on 8/1/11 at 2:30 p.m.,

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	indicated there were for the entire month often refuses; howe documentation in the of refusals. The Director of Nur was unavailable for 2. The record for R 8/1/11 at 1:30 p.m. included, but were received for the series of Physicia indicated Blood Gluat 6:00 a.m., and 4:00 Physician orders increceive Novolin Insective Novolin Insectiv	e no other blood sugars taken . She indicated the resident wer, there was no e resident's record of any type sing was not in the facility and interview. esident #3 was reviewed on The resident's diagnoses not limited to, diabetes. n orders, dated 7/2/11, toose Monitoring twice a day 00 p.m. Further review of dicated the resident was to ulin 70/30, 35 units every akfast. er Stick Blood Glucose Scale Insulin coverage ord for the month of July 2011 ucose was obtained at 4:00 5, 7/12-7/14, 7/18-7/22, /30. Further review of the aitoring Record indicated there se obtained on 7/2, 7/3, 7/6, 7/27, and 7/31/11. #1 on 8/1/11 at 2:30 p.m., nt's blood sugars were not a., as ordered by the physician obtained at all.		results have been placed in Admnistrator's office. A re-designed blood glucose monitoring form has been instituted for nurses to docublood glucose monitoring. 4 the corrective actions will be monitored to ensure the depractice will not recur? The Director of Nursing and/or designee audit blood glucose montioring forms on a daily to ensure that moniroting is done as ordered. Monitoring be on-going. 5. By what date systemic changes will be completed? September 15	ment How e ficient se basis being g will e the			

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Rether units and and units 25 units and and units 25 units and	eview of Physician of current 8/11 recaits at bedtime. The insulin sliding scaled on the current 8/11-200=2 unit-300=6 units, 30 its, and greater that nother Physician of cood Glucose moniment, and 4:00 p.m. eview of the Finger conitoring/Sliding Standard a blood gluber following days: here was no other but resident. The rely obtained four title 11. Eview of the Plan of the Plan of the Administrator feet on 6/2/11 for the Administrator for the Plan of the Administrator for the Administrator feet of for blood glucose f	orders, dated 9/20/10 and on p, indicated Lantus insulin 10 er resident also had orders for the of Novolog dated 9/20/10 11 recap, as follows: 0-150=0 ts, 201-250=4 units, 1-350=8 units, 351-400=10 to 1400=12 units. The details and content this with orders or designed with blood glucose or designed with blood glucose or designed with blood glucose or accuchecks and blood. The details and content this with orders for blood glucose or details and content this with orders for blood glucose or details and content this with orders for blood glucose or details and content this with orders for blood glucose ordered. If a resident is given to se that is not specific and the norders must repeat the order order.				

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CENTERS FOR MEDICARE & MEDICAID SERVICES					ONID 110. 0750-0371			
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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPI	LETED	
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NAME OF I	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				2075 R	IPLEY STREET			
LAKE PA	RK RESIDENTIAL	. CARE INC		LAKE S	STATION, IN46405			
(X4) ID	SUMMARV	STATEMENT OF DEFICIENCIES		ID			(X5)	
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TAG	.	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
		an for clarification. All blood						
	glucose monitoring	g performed must be recorded in						
	resident's record.	Γime blood glucose monitoring						
	done must also be	recorded."						
	Interview with the	Administrator on 8/1/11 at 2:45						
		re was documentation of any						
	*	ose monitoring audits performed						
	by the Director of							
	by the Director of	Nursing.						
		AT 111						
		N #1 on 8/1/11 at 2:30 p.m.,						
		re no other blood glucose results						
		cause staff did not do blood						
	glucose test. She i	ndicated the resident often						
	refused, however,	there was no documentation in						
	the resident's recor	d indicating any type of						
	refusals.							
	The Director of Nu	rsing was not in the facility and						
	was unavailable fo	-						
	was unavanable 10	i ilitelyiew.						
	This State Desider	tial Rule was cited on 5/11/11.						
		to implement a systemic plan of						
	correction to preve	nt recurrence.						

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